annd
Arab NGO Network for Development
شبكة المنظمات العربية غير الحكومية للتنمية

AMERICAN UNIVERSITY OF BEIRUT
FACULTY OF HEALTH SCIENCES

THE RIGHT TO HEALTH THROUGH A SOCIAL PROTECTION LENS

2023

Rana Jawad

Reader in Social Policy at the University of Bath

Walaa Talaat

Lecturer of economics at Faculty of Business, Ain Shams University

This report is published as part of the Arab NGO Network for Development's Arab Watch Report on Economic and Social Rights (AWR) series. The AWR is a periodic publication by the Network and each edition focuses on a specific right and on the national, regional and international policies and factors that lead to its violation. The AWR is developed through a participatory process which brings together relevant stakeholders, including civil society, experts in the field, academics, and representatives from the government in each of the countries represented in the report, as a means of increasing ownership among them and ensuring its localization and relevance to the context.

This 6th edition of the AWR focuses on the Right to Health. The AWR 2023 on the Right to Health is a collaboration between the Arab NGO Network for Development and the Faculty of Health Sciences at the American University of Beirut. Through this report we aim to provide a comprehensive and critical analysis of the status of the Right to Health in the region and prospects in a post COVID-19 era. It is hoped that the information and analysis presented in this report will serve as a platform to advocate for the realization of the right to health for all.

The report is published by the **Arab NGO Network for Development** (ANND). It can be obtained from ANND or can be downloaded from the following website: **http://www.annd.org**

SUPPORTED BY

Brot für die Welt | Norwegian People's Aid | People Change the World Diakonia

THE RIGHT TO HEALTH THROUGH A SOCIAL PROTECTION LENS

Rana Jawad

Reader in Social Policy at the University of Bath

Rana Jawad is Reader in Social Policy at the University of Bath. She specialises in the social policies and welfare systems of the Middle East and North Africa region and has published widely on the topic in a range of academic and international reports. She is co-founder and convener of the MENA Social policy network.

Walaa Talaat

Lecturer of economics at Faculty of Business, Ain Shams University

Walaa Talaat is a lecturer of Economics at the Faculty of Business, Ain Shams University. Walaa has a PhD in Development Economics and International Development from the University of East Anglia, United Kingdom. Her main areas of research looks at social policy, social protection, poverty, and health in the MENA region. She has a more general interest in social policy and climate change.

CONTENTS

INTRODUCTION: THE EVOLUTION OF THE CONCEPT OF SOCIAL PROTECTION IN INTERNATIONAL AND ARAB DEBATES ON DEVELOPMENT

The link between health and socio-economic outcomes, not least poverty, is well recognized in international policy and research debates (IMF 2020; ILO 2008), taking center stage in both the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDG) frameworks (ILO 2008). In social protection discourse, health is the first contingency of the lifecycle, making affordable, adequate, and accessible health services not only an indicator of well-being but also an outcome of successful economic growth in high-income countries and a vital pathway to development in low and middle-income countries (ILO 2008). Social protection, in particular, has a key role in mitigating ill health and addressing the social determinants of health (ILO 2022). Against this background, the main aim of this report is to provide a critical analysis of the current status and future prospects of the right to health through a social protection lens in the Arab region. The report focuses on the main social protection measures and strategic reforms driven by austerity measures and budgetary considerations in the post-COVID-19 era, in the context of weak regional social protection policies.

Given the assumptions of universality and adequacy of benefits in the right to health, the report covers the targeting and universal coverage dilemma in the region, including, actual responses during and post-COVID and Arab government philosophies of social protection. It does so by examining how Arab populations access health protection services through the following modalities: government-provided public health systems (which rely on taxation and government revenues); social insurance for formally employed private and public sector workers; social safety nets that include a health component (such as cash transfers); out of pocket expenditure (which is known to be very high in the region); and, finally, private medical health insurance (such as through occupational programs or market-bought services). To this end, the report distinguishes its focus from standard public health analysis by referring to Social Health Protection (SHP), defined below (ILO 2008).

The countries covered in the report are the 22 countries of the Arab League which fall into three categories according to their gross national income (Mokdad et al. 2014): low-income countries (LICs; Comoros, Djibouti, Mauritania, Yemen, and Somalia), middle-income countries (MICs; Algeria, Egypt, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, Sudan, Syria, and Tunisia), and high-income countries (HICs; Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates). The region is quite diverse economically and socially, resulting in different health status and public health outcomes. Poverty estimates vary considerably but exceed 50% in the poorest countries and in some countries engaged in active conflict (Mokdad et al. 2014).

Before proceeding, it is important to note the two main limitations in the analysis presented in this report. First, this report provides data about SDG 1 ("No poverty") and SDG 3 ("Good health and well-being"), particularly in the context of indicator 1.3.1 ("End poverty in all its forms everywhere"), and 3.8.1 (Coverage of essential health services). The most comprehensive and reliable data source we could find for this is International Labor Organization (ILO) World Social Protection Database (WSPDB) using ILO STAT. Measuring social protection effectiveness through effective coverage is a complex task that requires considering several dimensions to arrive at a comprehensive assessment. In practice, few Arab countries have available national statistical data necessary for such an assessment of coverage, and where available, data is often outdated. Furthermore, only partial information is available for some of them. As such, for consistency, this report relied on WSPDB using ILO STAT as the main source of global data on social protection, which is reported or imputed. The regional average of Arab countries is calculated for the available reported data for countries found at ILO STAT as shown in each figure.

Second, the concept of universal social protection applied in this report focuses on coverage and adequacy of benefits. As it has developed in policy and conceptual debates worldwide, the concept does not address intangible aspects of deprivation such as dignity, trust, and freedom which are indeed a core part of people's protection and empowerment but only assumed to be outcomes of effective social protection policies. There are studies worldwide that provide evidence of the beneficial effects of social protection on economic and social well-being, but here in this report, the focus is on mapping the existing systems and coverage in Arab countries and assessing ways in

which these might be improved. Hence, the report emphasizes the issue of access to social protection for all population groups throughout their lifecycle to achieve universality.

DEFINITIONS OF KEY TERMS

Universal Social Protection: is achieved through a nationally defined system of policies and programs that provides equitable access to all people and protects them throughout their lives against poverty and risks to their livelihoods and well-being This protection can be provided through a range of mechanisms, including in cash or in-kind benefits, contributory or non-contributory schemes, and programs to enhance human capital, productive assets, and access to jobs (USP2030 2015).

Social Health Protection: is a series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings or the cost of necessary treatment that can result in ill health (ILO 2008, p. 3)

Social protection: there is a wide set of definitions ranging from focus on marginalized groups to a right to income protection for all members of society. This report adopts the wider definition advocated by the ILO whereby social protection is a human right to income security and healthcare. Hence, it includes all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalized, with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalized groups (UNDP 2016, p. 15). For the rest of society, social protection is intimately connected with the lifecycle and the contingencies that may cause economic or social distress, such as maternity, retirement, and sickness.

Social protection floor: The Social Protection Floor (SPF) approach promotes access to essential social transfers and services in the areas of health, water and sanitation, education, food, housing, and life- and asset-saving information. It is an approach that emphasizes the need to implement comprehensive, coherent, and coordinated social protection policies to guarantee services and social transfers throughout the life cycle, with particular attention to vulnerable groups (ILO 2008).

Contributory schemes: are those where beneficiaries make regular contributions to a scheme that protects them in the

event of, for example, maternity, unemployment, or illness. Sometimes costs are matched or subsidized by the government. Insurance can be provided through public social insurance, insurance companies, or through mutual funds. Given that formal sector employment is usually male-intensive across the world, many existing contributory schemes perpetuate or reinforce gender inequalities, yet many social insurance schemes contain provisions that work towards closing gender gaps (UNDP 2016).

Social assistance (and non-contributory schemes): refers to targeted, state-financed schemes that extend a range of poverty relief services to poor populations who are often informal workers and/or self-employed. Such schemes include cash transfers, pensions, and health coverage to men and women with low incomes not covered by any formal contributory scheme such as work-based employment (UNDP 2016).

Social contract: As noted by Loewe and Zintl (2020), this concept refers to the "entirety of explicit or implicit agreements between all relevant societal groups and the sovereign (i.e., the government or any other actor in power), defining their rights and obligations towards each other."

GLOBAL FUNDING STATUS OF SOCIAL PROTECTION, REFLECTING PRIORITIES OF ARAB COUNTRIES

As outlined in Ortiz et al. (2017), there are various funding mechanisms for social protection around the world:

i. **Re-allocating public expenditures:** this includes assessing ongoing budget allocations through formal mechanisms like Public Expenditure Reviews (PERs) and other types of thematic budget analyses.

ii. **Increasing tax revenue:** this is achieved by changing different types of tax rates – e.g., on consumption, corporate profits, imports or exports, or natural resource extraction.

iii. **Expanding social security coverage and contributory revenues:** increasing coverage and, therefore, collection of contributions frees up space for government spending on social protection.

iv. **Lobbying for aid and transfers:** this requires engaging with either different donor governments or international organizations.

v. **Eliminating illicit financial flows:** this requires better control of money laundering, bribery, tax evasion, trade mispricing and other financial crimes.

vi. **Fiscal and central bank foreign exchange reserves:** this includes drawing down state savings and other state revenues stored in special funds, such as sovereign wealth funds.

vii. **Managing debt (borrowing or restructuring existing debt):** this involves active exploration of domestic and foreign borrowing options at low cost.

viii. **Adopting a more accommodating macroeconomic framework:** this entails allowing for higher budget deficit paths and/or higher levels of inflation without jeopardizing economic stability.

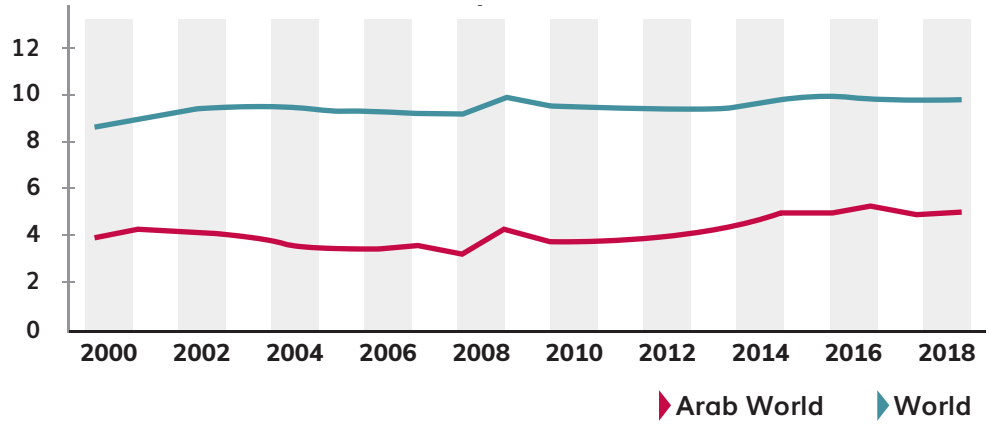
Comprehensive data on the patterns of financing social protection in the Arab region is patchy. We know that public expenditure on social protection (excluding health) averages 4.6% in the Arab region compared to a world average of over 12.9% (ILO 2022). Financial protection for healthcare takes three forms in Arab countries: (1) Government Health Insurance (GHI), (2) Private Health Insurance (PHI), and (3) Social Health Protection (SHP) (Alami 2017). SHP covers contributory schemes (typically called social health insurance) and non-contributory schemes, including community-based or social solidarity systems. Households not covered by the above categories must pay Out-Of-Pocket (OOP) or forgo healthcare.

The challenge in Arab countries is that extending coverage of financial protection means an extension of schemes in the formal labor sectors, with SHP targeting informal workers and the poor such as through the work of charitable organizations or international humanitarian agencies. The COVID-19 pandemic revealed some positive initiatives, such as the establishment of unemployment insurance schemes in Bahrain, Kuwait, Oman, and Saudi Arabia and enhanced coverage for maternity protection and informal workers in Jordan. The OECD (2020a) estimated that, on average, 2.7% of GDP was allocated to fiscal measures and 3.4% of GDP in liquidity injections was delivered by Central Banks across the Arab region during the first weeks of the pandemic. The region's fiscal deficit (IMF 2022) was projected to increase to 10.8% of GDP in 2020, raising concerns regarding the sustainability of the countries' economic response given the continued social and economic needs in the recovery period. The Gulf states showed the largest fiscal stimulus package that amounts to 6.9 billion USD,

whereas the LICs accounted for the lowest fiscal stimulus of about 0.27 billion USD (ESCWA 2022).

Coverage levels help to fill the picture of spending priorities. According to the International Labor Organization (ILO 2022), as of 2020, 40% of Arab populations were effectively covered by at least one social protection benefit compared to the global average of 46.9%. These rates hide inequalities and gaps within and between Arab countries, especially in relation to health protection and access: 39.5% of Arab populations have health coverage compared to a global average of 66%. The groups experiencing the highest exclusion rates are people with disabilities, the unemployed and mothers with newborns (all below 12%). Only 8.6% of women are legally covered by social protection compared to men (36.1%). The region also has the lowest level for maternity protection (12.2%) compared to a world average of nearly 50%. Arab states share the lowest ranking with the African continent on health expenditure (5.2%) compared to the world average (9.8%). **Figure 1** provides data on GDP % spending on health and shows that Arab country averages are well-below global averages.

Figure 1. Current Health Expenditure (% GDP)



Source: World Bank Data indicators, available at: https://data.worldbank.org/indicator

GOVERNANCE OF SOCIAL PROTECTION AND THE PATRIARCHAL APPROACH IN ARAB COUNTRIES

According to Batniji et al. (2014), the equitable distribution of public goods, such as healthcare, is so intertwined with accountability that some political scientists use measures of the distribution of these public goods as a measure of government political accountability. In republics, pension plan coverage is

double that in the monarchies of the Arab region (44% vs. 22%, respectively), which suggests that regimes dependent on their social achievements for stability are more likely to provide for their population. Another factor in determining the provision of public goods could be social division, or fractionalization, which can occur on social, ethnic, or religious grounds. Countries with greater social divisions have less access to healthcare, higher child and maternal mortality rates, and less investment in public goods.

Arab states are often described as having weak social contracts through neglect of public services, exclusion of certain population groups, and the use of violence against their citizens. Another distinguishing feature of the Arab region is the extent of external intervention in the form of colonialism, economic sanctions, foreign aid, military assistance, and military conflict that have contributed to, but do not fully explain, the failure to establish accountable and inclusive political systems in the Arab world. These political factors might explain variations in access to health services and health outcomes. According to Jamali et al. (2014), women are particularly disadvantaged in the labor market, which means that they also benefit less from social protection systems because they either have little prior experience of work, are perceived as not having the physical capacity, or have to look for work that fits their responsibilities at home. Hence, Arab countries follow what is called a "male breadwinner" mode of social policy (Alami 2017).

Reform efforts have remained patchy, partial, and contradictory even after the COVID-19 pandemic, with only a handful of countries like Morocco extending health insurance coverage to informal sector workers, which is financed through a combination of contributions and taxes, although OOP spending by households also continued to rise (UN-ESCWA 2022). Inequities continue to be a key feature of Arab health systems, and health sectors are still largely accounted for in terms of fiscal impact rather than for their contribution to welfare and social justice. Such policies are rooted in the non-inclusive macro-economic frameworks that have driven Arab economies, which focused on profiting networks of privilege and with political regimes characterized by cronyism, exclusion, and coercion. In this context, the preservation of power assumes priority over development goals, creating productive employment opportunities, and social protection. The COVID-19 pandemic put further pressure on health systems highlighting years of disinvestment and not even the right to universal

health in some countries, such as in Jordan. War, occupation, sanctions, civil strife, and insecurities have also put pressure on Arab public health systems. This region has the largest number of refugees and internally displaced and stateless people in the world, and the numbers are rising.

The patriarchal approach is evident in a range of patrimonial and authoritarian governance regimes: (1) the residual approach to social protection and social welfare issues, which favors provision through informal societal structures such as clientelism, the family, charitable and religious organizations, and tribal and community structures limits the economic and social freedoms of women, youth and older people as well as more progressive forms of social protection entitlement based on social citizenship; (2) at the national state level, there is a narrow set of dominant political actors such as the monarchy, military, prominent political families and business leaders who control the fundamental structures of decision-making in government that lead to a narrow focus on social protection as a social right.

As noted in Jawad, Walton, and Merouani (2021), Arab countries are neo-patrimonial. This form of political rule is based on "a hybrid that combines practices from the region's pre-modern state-building inheritance with bureaucratic structures partly imported from the West" (Bacik 2008:51). The neo-patrimonial state is usually considered "weak" in the sense of the ability to implement policies (Bill and Springborg 1994), and especially foster economic development, but, at the same time, it is quite robust in its combination of different kinds (personal and bureaucratic) of authority" (*Hinnebusch & Gani 2019, p. 4*). The neo-patrimonial approach of the region helps to explain the distorted governance of social protection through the concept of "limited access order" (North et al. 2009), which is founded on clientelism and enables rulers to control society and provide services. The most well-known characterization of governance in Arab countries is also the Rentier state model, which helps to reinforce the patriarchal decision-making processes around national wealth and social order. The presence of an allocation state, not based on extraction contracts, thus explains why the process of state formation in the Middle East has not followed a path of economic development, sustained reform, and democratization (Schwarz 2008).

THE MAIN METHODS OF FINANCING SOCIAL PROTECTION SYSTEMS IN THE ARAB REGION AND THEIR APPLICABILITY, WITH REFERENCE TO BISMARCK AND BEVERIDGE MODELS

According to WHO (2012 briefing), the distinguishing feature between the "Bismarck Model" and the "Beveridge Model" is the basis of entitlement to a benefit. In the Bismarck Model, entitlement is linked to a contribution made by a worker and, as such, membership of a corporate body is important such as affiliation with an employer in the case of workers. In the Beveridge Model, entitlement is based on citizenship or residence and, as such the benefit received is not dependent on previous contributions. Arab states have different strategies to provide social protections to their citizens in cases such as pregnancy and maternity or from the financial consequences of health risks. Countries vary in the extent to which they rely on non-contributory (tax-funded) national healthcare systems (the Beveridge model) or contributory social health insurance systems (the Bismarck model) (Loewe 2013).

In the Arab world, existing public health arrangements have disproportionately burdened Arab populations with high financial costs and hardship when using healthcare, with significant impoverishing and deterrent effects (Alami 2017). Health protection schemes are most comprehensive for those who can afford healthcare; they are mainly based on contributions and formal employment and thus fail to cater for the poor and the rural and informal sectors. Financing systems also lack the operational bases and institutional prerequisites for effective resource pooling and risk sharing, with segmentation and fragmentation worsening horizontal and vertical inequities. The neglect of public health systems has reinforced inequities by widening the gap between needs and provision and emphasizing the ability to pay as a basis for accessing quality care.

The state-centered developmental frameworks that characterized Arab countries after independence initially oriented most countries towards a Beveridge model — a national health system for all citizens financed through general taxation. "Most Arab public sectors were funded through a combination of payroll taxes and government revenues (often from oil), the latter remaining dominant in Iraq, Syria, and Libya. In the high-income Gulf states, it is oil revenues that dominate state social expenditure rather than taxation with the main political support base located among the urban middle

classes and ruling elites" (Alami 2017, p. 164). In trying to expand coverage from this starting point, most Arab systems have emphasized contributions and/or allowed opting out. While this may appear as a shift towards the Bismarckian model (a national health system financed mostly through contributions by employees, employers, and sometimes the government), in practice, most financing structures are mixed. The health systems are in need of upgrading, rehabilitation, and up-scaling, and responding to new shocks, not least the impact of war or in the case of the Palestinian people, occupation. As such, the region's increasing focus on promoting contributory insurance (Bismarck model) without strengthening risk-pooling or solidarity principles (Beveridge model) is likely to face important financial barriers. The gaps in coverage and barriers to financial access to health in the Arab region will further delay preparedness for Universal Health Coverage (UHC).

OVERVIEW OF HEALTH PROVISIONS IN THE EXISTING SOCIAL PROTECTION SYSTEMS OF THE ARAB COUNTRIES

Coverage and spending of social protection in the Arab countries are not only insufficient, but also inequitably distributed, both across subregions and countries and within the same country. Large segments of the population, including informal workers, unemployed, or those outside the labor force, are excluded from employment-related social protection, particularly women, young people, and non-national workers. Millions of key population groups, such as children, people with disabilities, and older people, have no access to effective mechanisms or social protection floors to protect their incomes, especially to finance their healthcare. Moreover, the protracted conflict-related fragility and humanitarian crises in countries across the region have imposed an additional burden on underdeveloped social protection systems. To obtain social justice in the Arab region, governments should establish universal social protection, including social health, and urgently realize the human right to social security for all. Doing so would contribute to decreasing poverty, containing inequality, enhancing human capital, fostering dignity, fairness, and solidarity, and strengthening the social contract (ILO 2021b).

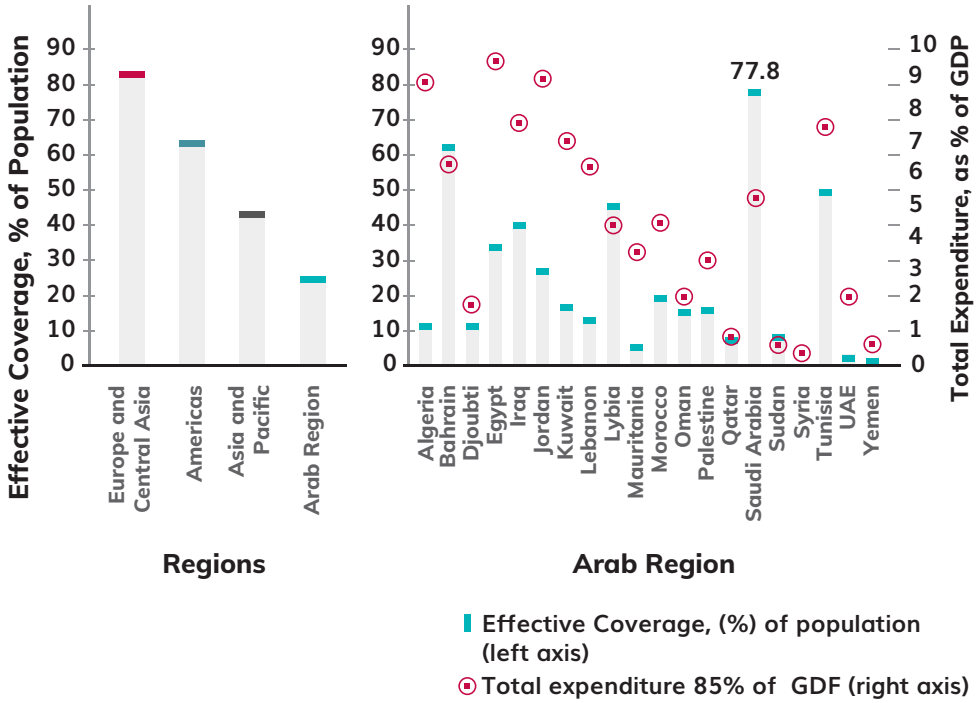
A LIFE CYCLE APPROACH TO SOCIAL PROTECTION FOR ALL IN THE ARAB REGION: AN OVERVIEW

As of 2020, only 46.9% of the world population was effectively covered by at least one social protection benefit excluding health (SDG 1.3.1: including, for instance, child and maternity benefits, support for persons without a job, persons with disabilities, victims of work injuries and older persons.), while the remaining around 4.1 billion people, accounting for 53.1% of the world population, were left unprotected. **Figure 2** shows that there are significant inequalities across and within regions, with the highest coverage rate in Europe and Central Asia and the Americas at 83.9% and 64.3%, respectively, and above the world average, while Asia and the Pacific and the Arab region coverage rates are 44.1% and 26% respectively, with far marked coverage gaps. According to an ILO report (2021a),

only 30.6% of the working-age population is legally covered by contributory schemes that include a full range of benefits, from child and family benefits to old-age pensions, with women's coverage lagging men's by a substantial eight percentage points. This implies that 69.4% of the world's population is only partially protected or not protected at all. Gaps in coverage, adequacy of social protection systems, and inclusiveness are highly associated with significant underinvestment in social protection, particularly in Asia and the Arab region.

Figure 2 depicts large variations in effective coverage across the Arab region. In the Gulf Cooperation Council (GCC) countries, on average, 31% of the population is protected through some form of social protection, compared to an average of 85.4% in high-income countries. Saudi Arabia and Bahrain display higher effective coverage rates since they provide social insurance coverage to non-national workers with a limited range of benefits. For instance, in Bahrain, social insurance for migrants is provided against old age, disability, and death. Differences in coverage across the GCC countries are a function of the extent of coverage granted to non-nationals and the proportion of non-nationals in each country's population. Spending and coverage in the conflict-affected and fragile countries of the region, such as Syria, Yemen, and Palestine, are very limited where less than 17% of the population are effectively covered through statutory social protection programs. Jordan and Lebanon are hosting refugees with low effective coverage rates, which reflect that they have very limited or no access to statutory national social protection schemes. In some cases, refugees benefit from emergency response. Coverage across upper and lower-middle-income countries in the region ranges from 77.8% in Saudi Arabia and 50.2% in Tunisia to a mere 13.9% in Lebanon and 2.8% in Yemen. These differences are due to the depth of coverage of contributory and non-contributory systems. Investment in social protection, excluding health, in the Arab region is insufficient, at an average 4.6% of GDP, below the world average of 12.9%. sector, as indicated in the following figures.

Figure 2. Population covered by at least one social protection benefit, and public social protection expenditure, excluding health, as a share of GDP, 2020 or latest available year



Source: Author's compilation, based on ILO 2020, World Social Protection Database, based on the SSI; ILOSTAT; national sources.

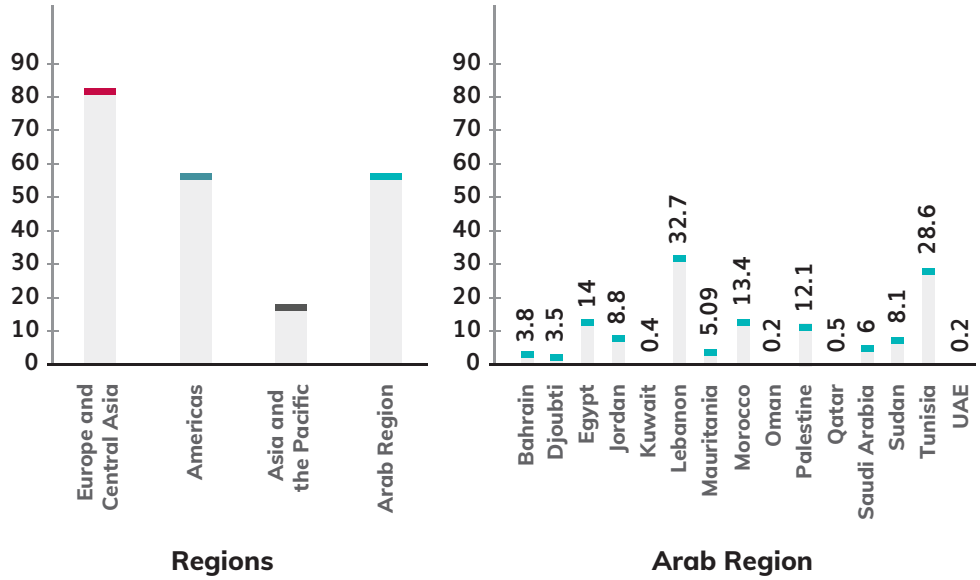
CHILDREN AND FAMILY BENEFITS

Coverage of children through social protection systems is low in the Arab region, especially in the GCC and other countries, as shown in **Figure 3**. Globally, around 26.4% of children are covered by social protection benefits. Children's coverage in the Arab region ranges from 32.7% in Lebanon to 0.2% in Oman. However, the Arab region lags behind in children coverage which accounts for 9.2% as compared with other regions such as Europe and Central Asia, the Americas, and Asia and the Pacific, which account to 82.3%, 57.4%, and 18%, respectively. Contributory child and family allowance play a critical role in improving children's coverage. These schemes exist mainly in Lebanon, Tunisia, and Morocco, covering 32.7%, 28.6%, and 13.4%, respectively. They contribute significantly to the coverage of children, although the adequacy levels differ greatly. Tunisia has gone through reform to strengthen social protection and increase investment in child well-being, aimed at achieving universal coverage of families with children through a multi-tiered model to extend non-contributory programs to all families not covered by contributory schemes (ILO 2021b).

Non-contributory child benefits are not common in the Arab

region. Whenever they are offered, they are given to certain targeted groups, such as children with disabilities, orphans, and foster children. As such, the vast majority of children are being excluded from these programs, such as in Palestine and Jordan. In Egypt, only 14% of children are covered through the social protection system, with, for example, 4 million children benefiting from the Takaful cash program that targets poor families with children. However, the eligibility criteria are narrow leading to limited coverage. In Morocco, some programs, such as education and healthcare services, are designed to respond to children's needs. Therefore, the limited social protection coverage of children in the Arab region raises concern, given the importance of investing in human development and protecting them from vulnerabilities (Machado et al. 2018).

Figure 3. SDG indicator 1.3.1 on effective coverage for children and families: Percentage of children and households receiving child and family cash benefits, 2020 or latest available year



Source: Author's compilation, based on ILO 2020, World Social Protection Database, based on the SSI; ILOSTAT; national sources.

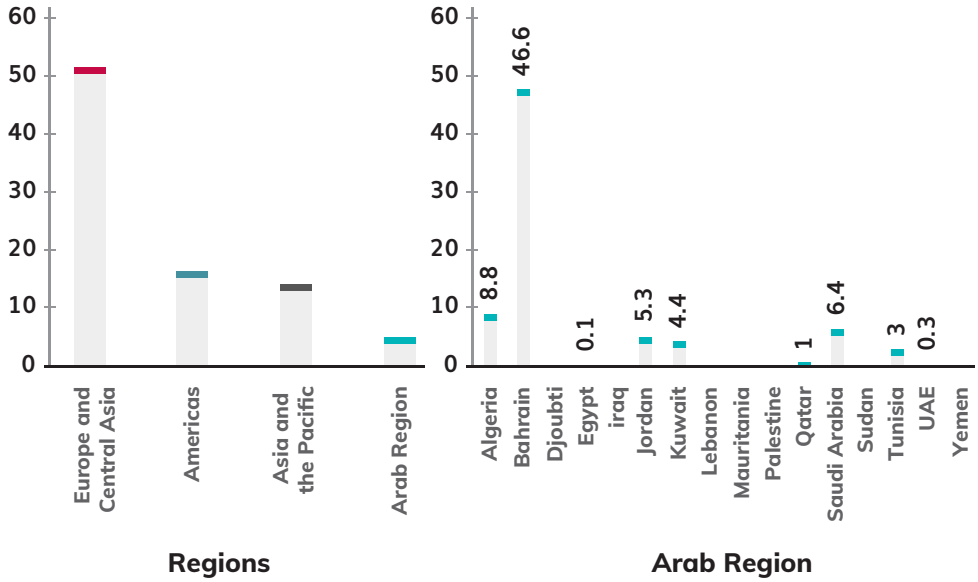
UNEMPLOYMENT BENEFITS

In the Arab countries, fewer than 10% of the unemployed have access to unemployment benefits, as compared with 18.6% worldwide and in other regions such as Europe and Central Asia, the Americas, and Asia and the Pacific 52.3%, 16.4%, and 14% respectively as shown in **Figure 4**. The unemployed are offered unemployment benefits through contributory and non-contributory schemes in Algeria, Bahrain, Egypt, Jordan, Kuwait, Morocco, and Saudi Arabia. Non-nationals are ineligible

for these benefits in Saudi Arabia and Kuwait or with restricted access in Bahrain and Jordan. In Bahrain, the percentage of unemployed persons receiving cash benefits reaches 46.6%, with non-national workers legally covered by unemployment insurance schemes.

When COVID-19 hit in 2020, it revealed the weakness and underdevelopment in systems of unemployment protection and labor market activation in the region (Bird & Silva 2020). There was a lack of solidarity in financing and risk-pooling across different sectors of the economy. Moreover, employer liability mechanisms suffer from weaknesses in terms of monitoring and legal enforcement of workers' rights, and exposure to bankruptcy and abuse risks. Some initiatives have been introduced in the Arab region to provide unemployment insurance schemes, such as in Lebanon, Tunisia, Palestine, and the United Arab of Emirates. In Jordan, unemployment insurance schemes have been used as a crisis response.

Figure 4. SDG indicator 1.3.1 on effective coverage for unemployment protection: Percentage of unemployed persons receiving cash benefits, by region, subregion 2020 or latest available year



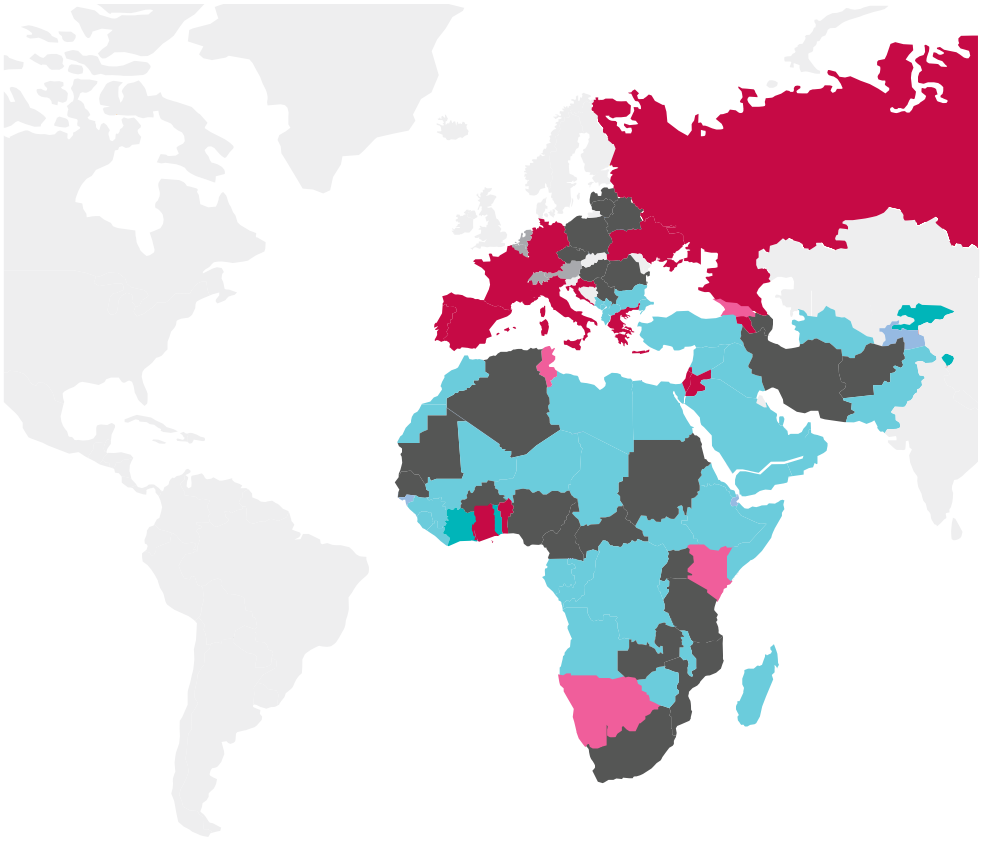
Source: Author's compilation, based on ILO 2020, World Social Protection Database, based on the SSI; ILOSTAT; national sources.

MATERNITY BENEFITS

Most countries in the world provide maternity provisions in their social insurance schemes. In contrast, countries in the Arab region generally provide paid maternity leave as an employer liability in their labor codes (ILO 2021b). Such arrangements

provide limited maternity protection with weak enforcement mechanisms and may discourage hiring female workers. The adequacy level of maternity benefits and their duration are also often longer and more generous in the public than in the private sector. In Tunisia, as shown in **Figure 5**, 23.5% of women giving birth received maternity cash benefits. Some countries in the Arab region have moved toward introducing social insurance schemes; however, with limited coverage, high informality levels, and low female labor market participation, for example, Sudan, Jordan, and Iraq (ILO 2021a). After COVID-19, Jordan introduced a childcare subsidy as a form of contributory maternity insurance scheme. However, no Arab country provides non-contributory benefits explicitly targeting pregnant women.

Figure 5. SDG 1.3.1 indicator on effective coverage for maternity protection: Percentage of women giving birth receiving maternity cash benefits, 2020 or latest available year

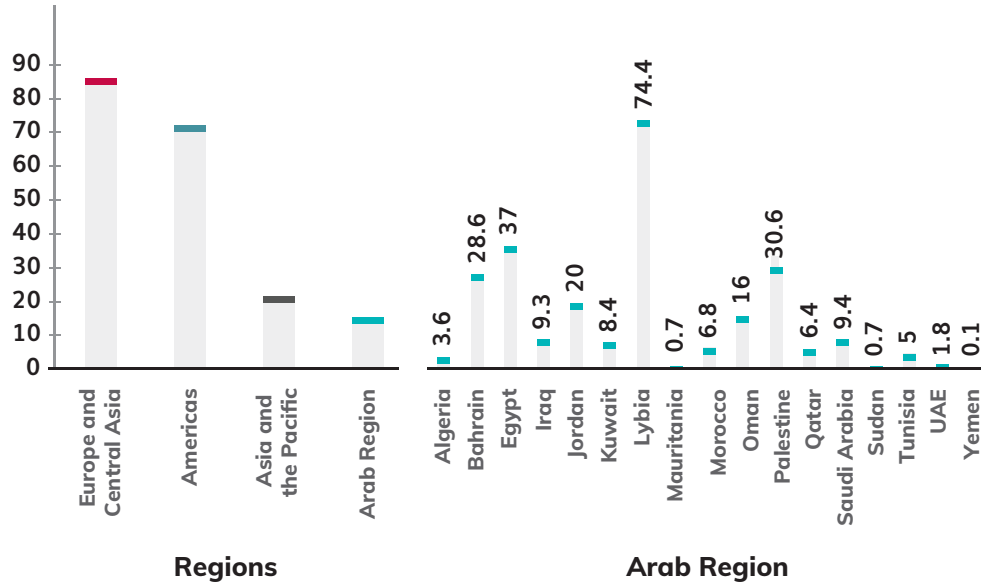


Source: ILO 2020, World Social Protection Database Maps, based on the SSI; ILOSTAT; national sources.

DISABILITY BENEFITS

Access to social protection benefits among people with disabilities globally reaches an average of 33.5%, as compared with low coverage in the Arab region, which reaches 15%, the lowest among other regions such as Europe and Central Asia, Americas, and Asia and the Pacific as shown in **Figure 6**. This is due to the limited coverage and low adequacy levels of contributory and non-contributory schemes in countries in the region, such as Sudan, Yemen, and Mauritania. Contributory benefits cover a small portion of people with disabilities, rarely in excess of 10%. Bahrain, Palestine, and Jordan have recently increased their coverage of people with severe disabilities using non-contributory benefits. In Egypt, 37% of people with severe disabilities receive disability cash benefits. For example, the Karama cash transfer program is provided unconditionally to people with disabilities. The main source of benefit coverage for people with disabilities is non-contributory schemes provided by ministries of social development. However, these benefits are inadequate and fragmented and do not sufficiently address the exclusion errors due to which the intended beneficiaries are not able to participate in the program, for instance, private cost, targeting technique, administration, and financial barriers. Most countries of the Arab region lack comprehensive and tax-funded schemes offered to those with disabilities. Therefore, some countries in the region, like Palestine and Lebanon, have identified a need to introduce disability benefits as part of a social protection scheme for those with disabilities (UN-ESCWA 2017; ILO 2021b).

Figure 6. SDG indicator 1.3.1 on effective coverage for people with severe disabilities: Percentage of people with severe disabilities receiving disability cash benefit, 2020 or latest available year



Source: Author's compilation, based on ILO 2020, World Social Protection Database, based on the SSI; ILOSTAT; national sources.

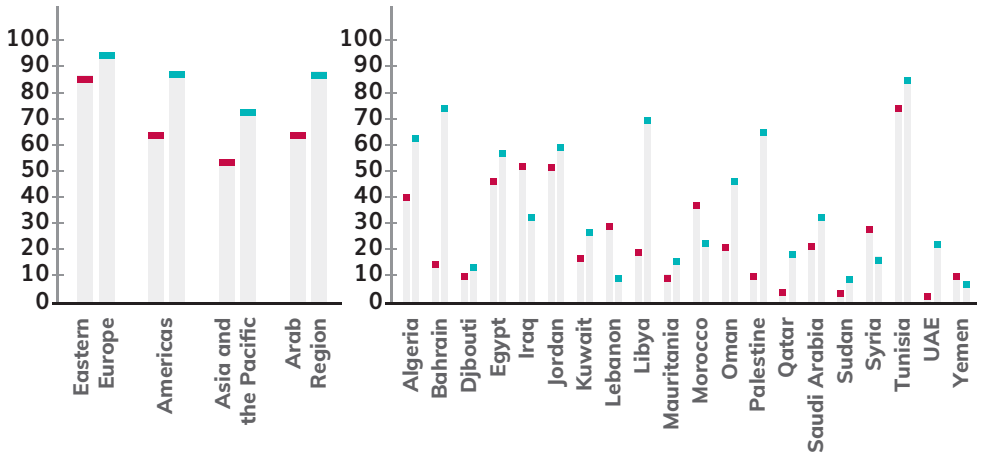
OLD AGE BENEFITS: PENSION SCHEME

Two important indicators are used to understand the implementation of statutory schemes: the percentage of persons above statutory retirement age receiving an old-age pension and active contributors as a percentage of the labor force. These provide an indication for those benefiting from existing contributory and non-contributory pension schemes and future pension coverage for those who are economically active in the labor force. An important cause for concern is that, at the global level, 53.7% of the global labor force contributes to pension schemes compared to 25.6% of the Arab region. This indicates that limited coverage is expected to receive a contributory pension upon retirement, as shown in **Figure 7**. This is due to the high levels of informality in the region, together with the lack of institutional capacity to ensure the enforcement of laws and fragile governance.

Only around 40% of older people receive a pension in the Arab region, less than the global average of 77.5%. Coverage rates are significantly high in countries with social insurance systems, such as GCC countries, Tunisia, and Jordan. However, Lebanon and Palestine have no scheme that provides periodic pension benefits for workers in the private sector, which is not sustainable (ILO 2021b). Some countries in the region provide

generous retirement conditions for public sector workers and benefit levels for pension schemes. On the contrary, some countries do not offer adequate minimum benefit guarantees in the absence of automatic pension-indexed inflation. Some countries, such as Egypt, Jordan, Oman, and Sudan, conducted reforms in merging retirement systems for public- and private-sector workers through a combination of institutional, systemic, and parametric reforms. However, the process of convergence is slow. Reform in Iraq has been delayed.

Figure 7. SDG indicator 1.3.1 on effective coverage for older persons: Percentage of population above statutory pensionable age receiving an old-age pension and active contributors as a percentage of the labor force, selected countries, 2020 or latest available year

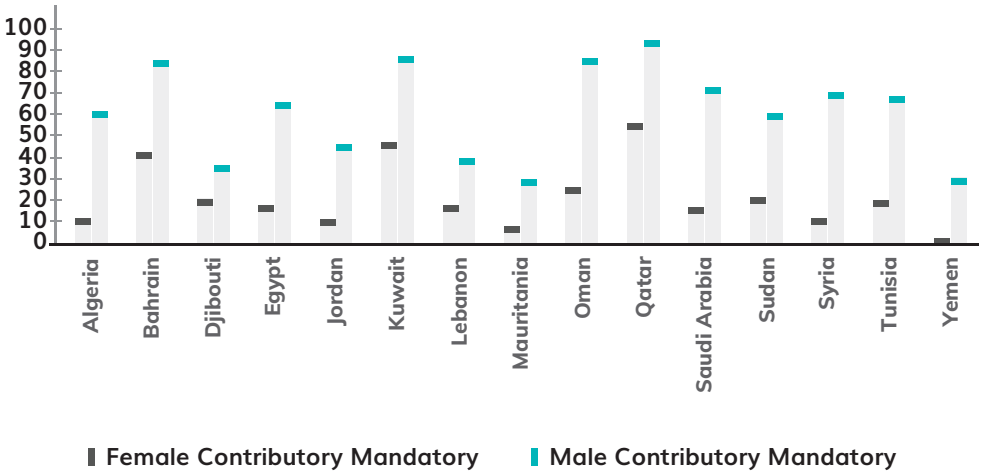


Source: Author's compilation, based on ILO 2020, World Social Protection Database, based on the SSI; ILOSTAT; national sources.

Contributory pension schemes are also characterized by a significant gender bias, as shown in **Figure 8**. For example, in Kuwait, women are less likely than men to benefit from a selection of contributory pension schemes by at least 40 percentage points. This infers low female labor force participation in the region. Therefore, the design of pension systems is tailored to those in stable, long-term, wage-employed careers (ILO 2021a). Non-contributory benefits for older people are rare in the region. However, Oman and Bahrain provide income security in old age, especially for

women. Non-contributory schemes covering families with older members are generally inadequate and cannot replace individual pensions based on broad coverage and universal entitlement.

Figure 8. SDG indicator 1.3.1 on effective coverage for older persons: Percentage of population above statutory pensionable age receiving an old-age contributory pension, by sex selected countries, 2020 or latest available year



Source: Author's compilation, based on ILO 2020, World Social Protection Database, based on the SSI; ILOSTAT; national sources.

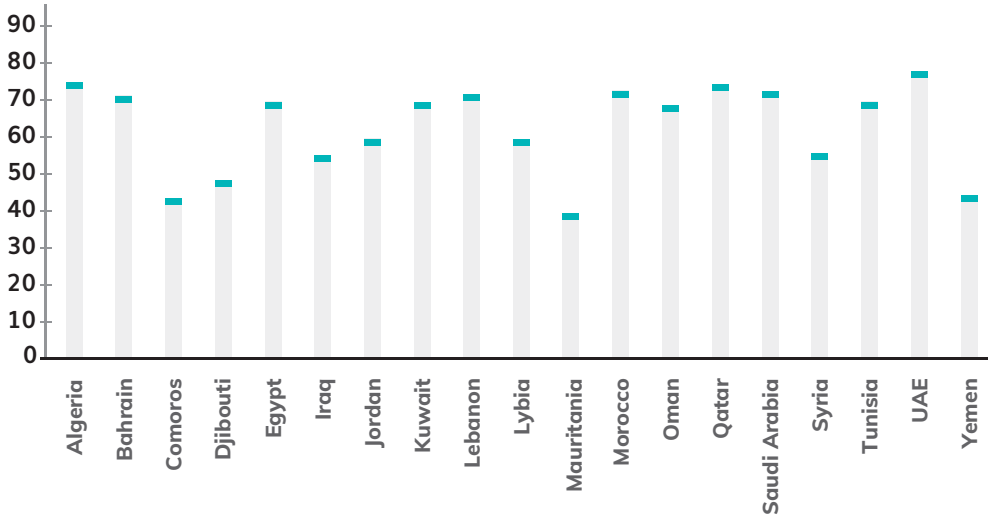
SOCIAL HEALTH PROTECTION SYSTEM IN ARAB COUNTRIES

Social health protection is measured by SDG target 3.8 to achieve UHC, including access to quality essential healthcare services, financial risk protection, and access to safe, effective, quality, and affordable essential medicines and vaccines for all; and the ILO Social Protection Floors Recommendation, 2012 (No. 202) that should guarantee first: access to essential healthcare, including maternity care, second: basic income security for children, providing access to nutrition, education, care, and any other necessary goods and services, third: basic income security for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability, and finally: basic income security for older persons. This is a key element of the human right to health and social security. The health system in the Arab region is complex and pluralistic, combining public and private providers and financiers. Providers compete, and citizens can choose services based on their needs and ability to pay. Consequently, the system relies on four primary financing

agents delivering health services under contributory and non-contributory schemes: the government sector, the public sector, the private sector, Civil Society Organizations (CSOs), and household OOP payments when adequate coverage is not provided.

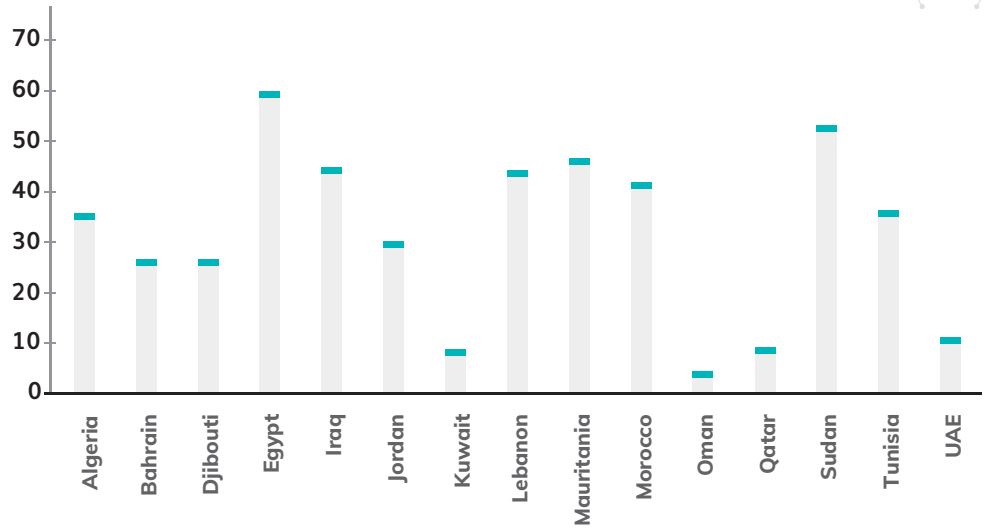
Social health protection in the Arab region is characterized by the low quality of service provided with limited coverage, as shown in **Figure 9**. UHC rates vary significantly among countries in the region, from as high as 78% in the United Arab Emirates to as low as 40% in Mauritania. Limited health access OOP payments are still high in the Arab region, as shown in **Figure 10**. This means that households are responsible for most of the healthcare costs, reflecting inequality in accessing healthcare services between urban and rural areas (ILO 2021). The distribution of spending for OOP payments as a percentage of health expenditure varies markedly across countries in the region. Most GCC countries have low OOP expenditure compared to other Arab countries. The OOP payment in Egypt and Sudan represents around 59.3% and 53%, respectively, of the health expenditure compared to 5% in Oman. Reliance on OOP spending reduces social solidarity and increases inequalities in accessing the healthcare system. After the Arab Spring, many countries prioritized health coverage in the new constitutions and national policy dialogues. However, most of the Arab countries still lagged in achieving the UHC targets. For instance, the region faces outdated national health accounts and poor data sharing across system levels (Alami 2022).

Figure 9. UHC Service Coverage Index (SDG 3.8.1) (%), 2019



Source: Data extracted from WHO Global Health Expenditure Database (WHO-GHED); latest available year modified in 2021

Figure 10. Out-of-pocket expenditure as percentage of current health expenditure (CHE) (%), 2020



Source: Data extracted from WHO Global Health Expenditure Database (WHO-GHED), latest available year modified in 2021

MIGRANT AND REFUGEE ACCESS TO SOCIAL HEALTH PROTECTION SYSTEMS IN THE ARAB REGION

Over 40 million migrants and refugees were hosted in the Arab region in 2019, which accounts for 15% of them worldwide. Around 50% originated from Arab countries and stayed in the region (UN-ESCWA 2020). According to the World Bank (2016), conflicts and wars in Iraq, Libya, Syria, and Yemen have led millions of people to leave their homes and flee to countries already suffering from economic burdens, such as Egypt, Jordan, Tunisia, Lebanon, and Djibouti. Despite the resources devoted by host governments and international bodies, they are exposed exponentially to dangers. The more migrants and refugees there are, the higher the percentages of poverty and risk exposure among them. If one looks at individual countries, the picture might become clear: in Yemen, since the beginning of the conflict in March 2015, around 190,000 people have fled the country, nearly 25% of them from Somalia, and over 2.1 million people have been internally displaced, with an estimation of around 80% of the population in need of humanitarian assistance. Many refugees have returned to Somalia, and the rest have moved to other countries in the region, notably Djibouti and Ethiopia, where they are hosted as refugees with limited access to basic services (UNHCR 2019).

With regards to the effect of conflict on the health of forcibly

displaced populations between and within countries, this has resulted in high mortality and morbidity rates from preventable causes, particularly within vulnerable groups either by age or gender. In addition, there are several challenges in providing them with social health protection except in the Gulf area, including those related to policy, programmatic and institutional capacity; for instance, weakened systems, funding, administrative barriers, coordination, and sustainable interventions, among many others. Therefore, providing social health protection for refugees and migrants is a challenge on both the supply and demand sides. On the supply side, limited access to health services is due to weakened health systems that vary across countries in the region. On the demand side, safety, together with epidemiological and demographic issues, lead to a high burden of both communicable and non-communicable diseases and mental illness among them, combined with other common diseases related to poor determinants of health, social status, and lack of access to basic health services. As such, resources devoted to health are unable to meet their needs. Migrants and refugees' situation underscores the urgent need to develop a comprehensive and integrated regional social health protection strategy to support their needs and strengthen and support healthcare systems in host countries. This strategy should aim at increasing the capacity, resilience, and preparedness of healthcare systems to promote a sustainable response that could address the health needs of both migrants and refugees together with the general public. It should also be based on the local legal context of each country in the region while ensuring the rights to access healthcare for migrants and refugees. This is an opportune time for revising the relevant legal frameworks for the rights of social health protection (UNHCR 2019).

The role of international organizations is central in supporting access to healthcare and providing social health protection in the Arab region for migrants and refugees. Some Arab countries incorporate the right for refugees their national laws and policies. In contrast, others have drafted policies such as Memorandums of Understanding (MOU) between international organizations and hosting governments to ensure their access to essential healthcare services. The World Health Organization (WHO) global action plan 2019-2023 identified a set of priorities to guide international organizations (including the WHO itself, the International Organization for Migration (IOM), the United Nations High Commissioner for Refugees (UNHCR)), member states and non-state actors in promoting the health of refugees and migrants. These priorities include: promoting the health

of migrants and refugees through short-term and long-term public health interventions; advocating the mainstreaming of migrants' and refugees' health into global, regional, and country agendas; promoting refugee-sensitive and migrant-sensitive health policies and legal and social protection, which include the health and well-being of women, children, and adolescents, gender equality and empowerment of migrants and refugees women and girls; promoting continuity and quality of essential healthcare, while implementing and developing occupational health and safety measures; accelerating progress towards achieving SDGs including UHC by enhancing capacity to tackle the social determinants of health; strengthening health monitoring and information systems; and supporting measures to improve evidence-based health communication to counter misperceptions about migrants and refugees health (Onarheim & Rached 2020).

Migrants, refugees, and displaced populations require social health protection that mainly focuses on mental health protection and support due to the vulnerabilities they are exposed to, beginning with basic services, such as access to food, water, shelter, healthcare, and other mainstream services. An example is Sphere Project's (2018) mental health standards, cowritten with WHO and is being developed in collaboration with UNICEF and other partners to support migrants and refugees. However, health systems in the Arab region struggle to cope with their needs, and henceforth, women and children mainly face severe challenges. For example, the total number of all deliveries in Lebanon is 73,000 childbirths per year in the Lebanese population, compared to 39,000 deliveries in the Syrian refugee population. Such high numbers of deliveries pressure national health systems, especially reproductive, maternal, and child health services. To end preventable deaths among all women, children, and adolescents and to greatly improve their health and well-being, countries should follow the guidelines and standards for Reproductive, Maternal, Newborn, Child, And Adolescent Health (RMNCAH) services. However, these are non-existent, fragmented, or poorly implemented in displacement settings. Moreover, RMNCAH available data and information among migrants, refugees, and displaced populations, and coordination and integration in humanitarian settings remain insufficient, as does social and financial protection. Possible solutions should lurk in integrating RMNCAH with national frameworks' preparedness plans to ensure healthcare quality services are provided to women, children, and adolescents, which should be sensitive to their needs and situation (WHO 2019).

RESPONSES FOR CHANGING REALITIES IN THE ARAB REGION: COVID-19

Before the COVID-19 pandemic, less than 30% of the population in the Arab region were covered by social protection programs, including health. Most of these programs were funded through government budgets or external assistance and not through beneficiaries' or employers' contributions. The pandemic spotlighted the problems of the social contract between people and governments. Spending levels on COVID-19 in the Arab region varied largely from one country to another, however it remained lower than global spending. In the region, 3.9% of the GDP was spent on the pandemic compared to a global average of 22.6%. The Gulf countries spent the most, around 69.9 billion USD, compared to 24.78 billion USD spent by all the remaining Arab countries. Not only did the spending levels vary across the region, but the sources of spending differed from one country to the other. In Morocco and Tunisia, the private sector provided funds worth 104.5 million USD and 410 million USD, respectively. While most Arab countries reprioritized their public spending or created special funds, countries in conflict relied mainly on donor funding and humanitarian aid.

Additionally, spending on the pandemic went towards different areas, including social insurance, loan and tax benefits, social assistance, labor market interventions, health-related support, financial and general policy support. In this context, Arab countries devoted nearly 18% of fiscal support for social protection. For example, Somalia allocated around 100%, followed by Lebanon with 96.8% and then Iraq 95%. Oil-exporting countries prioritized temporary tax reductions, extended deadlines for payments and increased other spending to preserve jobs, while oil-importing countries focused their spending on health and targeted social transfers (UN-ESCWA 2021).

Before COVID-19 in 2018, health spending as a percentage of GDP ranged from a low of 1% in Sudan to 4.4% in Kuwait, with a regional average of 2.9%. This level of spending is relatively moderate compared to the global average of 5.87% for the same year. Overall, in the region, health spending between 2015-2018 was relatively steady, accounting to 3% of GDP. Notably, this should have urged policy makers to increase health spending to improve health services, which is essential especially with high levels of poverty and unemployment in the region. After COVID-19 hit the world, it revealed the extent to which heath systems in the Arab region are fragmented and

primary care is underserved. It highlighted the health systems' uneven capacity and deep inequalities (UN 2020). According to the Global Health Security Index (2021), one-third of Arab countries have less than 10 healthcare providers per 10,000 people, while the richest third of countries have at least a range of 50 to 70 providers per 10,000 people.

The regional doctor-to-population ratio is 2.9 per 1,000 people, below the world ratio of 3.42 per 1,000. Similarly, this trend was observed in intensive care units, hospital beds and primary care, with a large variation between and within countries for rural and urban areas. On average, 61% of the population in the region can access health services, however, this rate varied significantly among countries and even within individual countries, from 77% in Kuwait to 22% in Somalia. Similarly, OOP expenditure on health varied from 37% of the cost to 88% in poorer countries, threatening the ability of households to meet their basic needs. Moreover, social health protection schemes are often fragmented and do not cover the unemployed and workers in the informal sector. Despite the ongoing emergency health response and efforts undertaken in the region to enhance access to health services, the costs of testing and healthcare, as well as falling ill are likely to have a devastating consequence on poor households with the potential to push tens of millions of people into poor health and poverty (UN 2020).

RECENT KEY SOCIAL HEALTH PROTECTION REFORMS IN THE ARAB REGION

To implement contributory health insurance, governments are challenged to improve the sustainability of health insurance funds and to broaden coverage of these funds, especially to informal workers and low-income groups to better protect them from the impact of lifecycle risks. However, these two goals, fiscal pressure and coverage gap, are hard to achieve, therefore non-contributory schemes are provided to limit the challenges of coverage, sustainability, inclusiveness, and adequacy level of health benefits. Countries in the Arab region have introduced several reforms to overcome the challenges mentioned above.

CONTRIBUTORY HEALTH PROTECTION

In Jordan, the government expanded health insurance coverage in 2004 by adopting a civil health insurance law to include older people, starting with those over 80 and then over 70, reaching everyone aged over 60 in 2017 (135,000 persons). Also, the coverage expanded in 2018 to include free access to healthcare

for beneficiaries of the National Aid Fund, children under six, and persons with disabilities. Similarly, in Sudan in 2015, the national health insurance program extended its coverage to subsidize older people, poor households, and people with disabilities (UN-ESCWA 2019).

From 2000 until 2005, the Palestinian government extended free coverage via a health insurance scheme to all unemployed persons and their households. Consequently, the coverage of health insurance increased from 204,350 to 343,318 beneficiaries. In 2007, it was decreed that all households in the Gaza Strip should be exempt from paying contributions. Health insurance is offered to those benefitting from social assistance and imprisoned persons. The number of social assistance beneficiaries in the West Bank benefitting from health insurance on this basis increased from 10,942 in 2008 to 41,198 in 2017 insured households. The number of prisoners' households covered by health insurance increased from zero to 17,882 from 2009 to 2017, respectively. These reforms appear to have worked well in terms of coverage since the proportion of Palestinian households covered by health insurance increased from 48.6% in 1997 to 66.2%.

In 2004, Tunisia adopted a law establishing a new health insurance regime in which social insurance and health insurance are bundled together. This reform resulted in covering both workers from the public and private sectors on the same basis. As such, the coverage of private sector workers has since risen very sharply from 1,162,446 in 2002, meaning that 54%of all such workers were covered, to 2,362,839 in 2017, lifting the coverage rate to 81% (UN-ESCWA 2019).

In Egypt, the 2014 constitution affirmed the universal right to healthcare, safeguarded by building and maintaining an inclusive and effective healthcare system. The government has developed an ambitious long-term plan to reform the national health system, adopted by parliament in 2017. To achieve target 3.8 on UHC, the government must allocate not less than 3% of GDP to health. The increasing cost of healthcare in Egypt is a challenge. In 2018, 62.8% of health expenditures were paid OOP. Fragmentation is another challenge. A member of the same household could benefit from various schemes under different programs, each with its regulations, which makes it difficult to unify health services. Moreover, due to widespread informality, some workers are not covered by any health insurance scheme. This problem is further exacerbated in rural Upper Egypt, where workers are the least educated and most disadvantaged.

In Egypt, Law No. 2 of 2018 on universal health insurance was adopted to address healthcare challenges. Phase one began in five pilot governorates: Port Said, Suez, Ismailia, North Sinai, and South Sinai. It will be expanded to the entire country over ten years. The new law mandates health insurance for all citizens except those living abroad. Employers must contribute 4% of the employee's salary or a minimum of 50 Egyptian pounds, and employees contribute 1% of their wage, adding an additional 1% per child or dependent and 3% for a non-working spouse. Those who receive pensions contribute 2% of their monthly pension. In addition to contributions, universal health insurance will be financed by taxes on cigarettes, highway tolls, corporate revenue, application and renewal fees for various licenses, payments made to join the health insurance system, and external and internal grants and loans. The new law provides a health subsidy for those unable to make contributions, under which the government contributes 5% of the minimum wage per family member. Eligibility for the health subsidy will be determined according to targeting criteria, and the government plans to cover approximately one-quarter to one-third of the population. Nevertheless, the government is expected to face several challenges (Talaat 2022).

NON-CONTRIBUTORY HEALTH PROTECTION

Some countries in the Arab region allow certain categories to be covered by contributory health insurance schemes for free or on a subsidized basis. Other countries have established or complemented contributory schemes by providing specific non-contributory healthcare schemes for the poor and vulnerable. These schemes, which share many characteristics with cash-transfer programs, mainly rely on targeting. In Lebanon, since 2011, beneficiaries of the National Poverty Targeting Program (NPTP) can access private and public hospitals at a reduced cost, for which the Ministry of Health can pay around 90% of the hospital tariff.

In Tunisia, a non-contributory health provision scheme is offered to poor and vulnerable households who are enrolled in Assistance Medicale Gratuite I and II Programs that provide free access to care at public hospitals and health coverage on a heavily subsidized basis. The health benefit reached 622,000 households in 2018. In Morocco, the 2002 law mandated that a special non-contributory health provision scheme, named RAMED, must offer free health coverage to the poor while vulnerable households must pay a small contribution. RAMED has been operational in parts of the country since 2008 and covered the whole country in 2012, reaching 11,866,735 beneficiaries in 2018 (UN-ESCWA 2019).

THE MULTIDIMENSIONAL ROLE OF ARAB STATES AND THE INCREASED RESPONSIBILITY OF CIVIL SOCIETY ACTORS

Arab health systems have undergone similar transformations to other developing countries towards greater reliance on private and charitable sector provision due to the neoliberal economic reforms of the 1980s and 1990s and the austerity measures which followed in the 2000s. What is distinctive about the 'commodification' of healthcare in the Arab region is that most Arab countries went against the international trends of reducing OOP spending by investing in public health. As a result, financial burdens on citizens in the MENA region have not improved even when fiscal space opened up in the 2010s, later to be put to the test by the COVID-19 pandemic, as noted above.

TYPES OF APPROACHES ADOPTED IN DIFFERENT SUB-REGIONS BY THE STATE AND PRIVATE SECTOR

Most Arab countries have a public healthcare system funded primarily by the treasury. The eligibility criteria and access patterns vary across countries and do not always match political regimes or national income levels. For example, Oman, Sudan, Syria, and Yemen have historically offered free of charge healthcare to all residents. In contrast, in Bahrain, Qatar, Kuwait, Saudi Arabia, and the UAE, free healthcare is only available for nationals and citizens (Loewe 2013). In Jordan and Iraq, only civil servants and military personnel are treated for free; all others must pay user fees, although these are heavily subsidized. Tunisia and the West Bank have social health insurance systems that operate their healthcare systems. These healthcare systems are primarily financed from the premiums of health insurance systems but also receive subsidies from the Treasury (Loewe 2013). They are freely available only to members of the health insurance scheme, while the uninsured have to pay modest user fees. Algeria and Libya both have a public healthcare system and a healthcare system owned by the respective social health insurance organization. The public healthcare system pays for its costs mainly through tax revenues, but it is co-financed by the social health insurance organization from the premiums collected from the members. However, the socially insured and the uninsured are entitled to free medical treatment. The difference between both countries

is that in Algeria, the insured may also go to private healthcare providers, and they are then reimbursed for 80% of the cost.

Egypt also has both a public healthcare system and a social health insurance scheme. The public scheme is run by the Ministry of Health and financed by the treasury from general taxes. It is open to all residents free of charge. At the same time, the health insurance scheme runs its system of healthcare, which is for the benefit of its members only – but not their relatives. It is financed from social insurance contributions, gets funds from the treasury, and has a much higher standard than the public system. Lebanon also has a social health insurance scheme and a public healthcare system. The insured and the uninsured can refer to the public healthcare system and private providers. However, in both cases, they have to pay high user fees. Morocco and Mauritania have public healthcare systems, which are only partly financed by the treasury from general income tax and charge relatively high user fees. Morocco has started building a social health insurance scheme, which takes over the fees paid for healthcare services. It also provides households in need with identification cards that entitle them to free use of the public healthcare system. This effort was accelerated during the COVID-19 pandemic (ESCWA 2022).

Even within government-provided facilities, considerable differences in benefit packages and access to facilities persist, generating horizontal inequalities. For example, Jordan's Civil Health Insurance covers ministers and employees. However, only the former can access first-class services (including private providers) and have a comprehensive benefits package (inpatient, outpatient, diagnosis, rehabilitation, etc.). Likewise, in Lebanon, hospitalization class depends on the health insurance category, with some high officials exempt from contributing but entitled to a comprehensive package (El Khoury 2012). An even higher level of fragmentation is reported in Egypt, with the best state hospitals reserved for the ruling elites, which can also use private care (El Laithy 2011).

SOCIAL PROTECTION AND TAX POLICIES: FINANCING STRATEGIES AND FRAMEWORKS

In recent policy debates, social protection and tax have emerged as two of the key policy instruments available to governments in the pursuit of development goals (Bastagli et al. 2021). Both feature prominently in the Sustainable Development Goal (SDG) and Financing for Development (FFD) processes. Social protection and taxation interact to shape the distribution and redistribution of income and wealth

directly, through the incidence of taxes and transfers. They also interact to shape the resources available for social spending by influencing government accountability and legitimacy processes, the quality of service provision, and people's willingness to pay taxes. Some key principles are:

1. Taxes and transfers can be a powerful redistributive tool;
2. Tax and transfer design and implementation details matter; and
3. Variations in the levels and composition of revenue, or 'financing mix,' have implications for distributional outcomes and policy sustainability.

Below is a summary of the main strengths and weaknesses of taxation in relation to other social health protection funding mechanisms. **Table 1** below shows the different kinds of health financing mechanisms, and **Table 2** shows the strengths and weaknesses of each one, including taxation.

Table 1. Scope of health financing mechanisms

Government revenues	Payroll taxes	Premiums/ CBHI	Premiums/ PHI	Out-of-pocket payments
Equity depending on design of tax system	Coverage of formal economy	Resource collection from the non-salaried	Increases fiscal space	Easy to administer
Coverage and outreach	Increased fiscal space	Allows to target public funds to the poor	Allows to target government funds to the poor	
Sustainability	Public support	Increases fiscal space		
Potential for efficiency	Financial soundness	Potential to reach out to those who can pay or are subsidised		
	Allows to target government funds to the poor			

Source: From ILO 2008

Table 2. Pros and cons of the different funding mechanisms of social health protection

Mechanism	Pros	Cons
Tax-based health protection	Pools risks for whole population	Risk of unstable funding and often underfunding due to competing public expenditure
Coverage and outreach	Potential for administrative efficiency and cost control	Inefficient due to lack of incentives and effective public supervision
	Redistributes between high and low risk and high- and low-income groups in the covered population	
Social health insurance	Generates stable revenues	Poor are excluded unless subsidized
	Often strong support from population	Payroll contribution can reduce competitiveness and lead to higher unemployment
	Involvement of social partners	Complex to manage governance and accountability can be problematic
	Redistributes between high and low risk and high- and low-income groups in the covered population	Can to lead to cost escalation unless effective contracting mechanisms are in place
Micro-insurance and community-based schemes	Can reach out to workers in the informal economy	Poor may be excluded unless subsidized
	Can reach the close-to-poor segments of the population	Maybe financially vulnerable if not supported by national subsidies
	Strong social control limits abuse and fraud and contributes to confidence inthe scheme	Coverage usually only extended to a small percentage of the population
		Strong incentive to adverse selection

		Maybe associated with lack of professionalism in governance and administration
Private health insurance	Preferable to out-of-pocket expenditure	High administrative costs
	Increases financial protection and access to health services for those able to pay	Ineffective in reducing cost pressures on public health financing systems
	Encourages better quality and cost-efficiency of healthcare	Inequitable without subsidized premiums or regulated insurance content and price
		Requires administrative and financial infrastructure and capacity

Source: From ILO 2008

As Megersa (2019) notes, social protection and taxation are two interrelated policy instruments that have a major role in advancing the capacity of fiscal policy to influence development, equality, and the Sustainable Development Goals (SDGs). Developing countries are faced with the option of raising government revenues for social protection through taxation and social security contributions. However, these remain challenging because tax authorities have weak capacity and lack transparency. At the same time, a large share of the population is informally employed, which makes it difficult and costly to collect social security contributions or tax employees. According to the ILO, these challenges limit the means to redistribute income and develop effective social protection systems (ILO 2016). A key measure for fiscal expansion already being used in Arab countries is the removal of ineffective tax subsidy policies (e.g., Jordan, Egypt, Morocco, Oman, and Lebanon). Moreover, taxes on natural resources in resource-rich countries can support social spending and generate overall economic growth. This approach could be better implemented in the region's oil- and gas-rich states.

Taxes and social transfers are often discussed separately, but they have evident interconnections in practice and influence the distribution and redistribution of income and wealth. As noted by Bastagli (2015), when studies examine social protection independently from tax policy, they generate an incomplete picture of the impact of fiscal policy (Bastagli 2015a; 2015b) since the net effects of government spending and taxes make the poor worse off, hence the need for implementing

a comprehensive approach which includes both taxes and spending (as can be seen in Jordan and other Arab countries below).

Taxation is especially significant – when compared with other social protection financing alternatives, like expenditure reallocation and dependence on external financing – because it has the capacity to redistribute wealth in a much more profound way and support social citizenship. Taxation has the potential to create and strengthen government legitimacy and state-citizen relations (UNRISD, 2019). External financing and revenue earned from natural resources and consumption taxes have been crucial to backing the establishment or enlargement of social protection programs. Arab countries suffer from a relatively low tax-to-GDP ratio, making them more dependent on international aid and financial support. This raises equity and sustainability issues, some of which can be resolved through the transparent management of resources and by creating tax and transfer policies that address equity and broader development concerns (Bastagli 2015a).

Various Arab countries have approached this issue of tax reform in different ways, as can be seen below:

- Jordan: the reduction and, in some cases, removal of subsidies on different types of petroleum products has lowered the government's fiscal burden and supported some improvement in social protection coverage, such as cash transfer schemes to vulnerable households. However, this reform sparked resistance and possibly also increased tax evasion.
- Egypt: the increase in government taxes and the termination of energy tax subsidies (among other policies) has led to targeted social 'solidarity' programs – including pension schemes, healthcare provision, and education. However, rising poverty rates remain an issue, and recent reforms (higher taxes and cuts to subsidies) affected living costs for many households.
- Oman has cut ineffective tax subsidies on different items and focuses on diversifying its economy (and source of tax) – away from oil. The country has also implemented a comprehensive social protection system, including universal medical care, programs for disabled people, children, migrant workers, and free/compulsory education.
- Algeria has sought to enhance social protection provision through taxes on tobacco, alcohol, and pharmaceutical imports.

According to the IMF (2022), improvements in tax policy design can help widen the tax base and increase the redistributive capacity of the state: there are key elements of this perspective that apply to the Arab countries. First is the reduction of tax exemptions on personal and corporate income. This measure can help to expand the tax base by restricting "generous and distortive tax exemptions—including those introduced during the COVID-19 pandemic", leading to improvements such as greater allocative efficiency, simplification of tax administration, and reduction of non-compliance. A case in point is Egypt, where a reform of income tax law is underway to simplify the legal framework and rationalize exemptions. Second, improving the design of the VAT is another important measure of tax reform. The IMF (2022) argues that exemptions on basic goods and services, including foodstuffs and medication, aimed at lowering the tax burden on vulnerable households, in effect, benefit high-income households and distort market prices. These exemptions can be replaced by better-targeted cash transfers, which may be financed using consumption tax revenues (Warwick and others 2022). VAT progressivity can also be improved if additional revenues are used to finance spending on social programs, education, health, and infrastructure (IMF 2020).

The weaknesses of taxation systems in the Arab countries were brought to the fore following the COVID-19 pandemic response. Although countries in the Arab region, like Morocco and Egypt, were quick to introduce tax-financed cash transfer schemes, the high levels of labor market informality mean that the social insurance base of social protection is small and not well adapted to emergency situations. The productive inclusion of youth can help broaden the base of contributory social protection and the tax base for non-contributory programs.

THE ROLE AND CONTRIBUTIONS OF CIVIL SOCIETY AND RELIGIOUS GROUPS

2015–2025 has been called the "Arab decade for civil society organizations" by the WHO and Arab States (2015) following a region-wide consultation in 2015. The decade provides a platform for strengthening and mobilizing civil society organizations in the Arab region to become effective partners in achieving the SDGs. WHO is cooperating with this initiative by helping to identify the specific role that civil society organizations can play in achieving SDG 3 (the health goal).

Civil society organizations have a key role in the progress of the health-related SDG agenda, including health literacy, advocacy, social mobilization, and service provision, especially

in countries in crisis and emergency situations. Religious welfare movements and organizations already provide health services to poor populations and their membership base (Jawad, 2009; 2019). Their role is controversial due to their wide range of services and the extent to which these exacerbate social divisions and discrimination. This is especially true in the MENA region, where religious divisions are deep and sometimes politically divisive. In the Arab region, the number of civil society organizations per country varies but is increasing in number and influence. Civil society organizations are weakest in the Arab Gulf monarchies and military-ruled states like Egypt and Libya. They play a crucial role in addressing population health problems, providing institutional vehicles to address community needs and expectations, and complementing government action through implementing programs not considered a priority or targeting marginalized groups. Civil society organizations also provide frontline services in countries with acute crises where governments are weakened or partially absent (more than half the countries in the region). They facilitate community interaction with services such as hygiene, water, and sanitation, support access to vaccines and promote health through information dissemination, such as in Ebola virus disease outbreaks and natural disasters, and for smoking prevention and promotion of healthy diet and physical activity. They also influence policy development, for instance, through the Framework Convention on Tobacco Control and HIV/AIDS, and contribute to resource mobilization, including for polio eradication and girls' education.

The role of civil society organizations and the importance of partnership with civil society are not well recognized by governments in the Arab region, except where religious welfare is involved. However, even in the latter case, many governments collect Zakat formally and distribute it in the form of social assistance. In many countries, legal frameworks for establishing civil society organizations are lacking or have become tighter, such as in Egypt. Consequently, low trust exists between governments and civil society, and coordination is difficult. Additionally, there is a weak culture of volunteering in the region and poor understanding of its importance in development. Furthermore, cultural and social norms prevent specific groups from participating in civil society. Specific challenges related to civil society organizations include weak strategic planning, inadequate staff capacity, and weak governance and management, with often limited transparency in funding.

DISCUSSION

TOWARD UNIVERSAL SOCIAL PROTECTION SYSTEMS IN THE ARAB COUNTRIES

i. Before COVID-19, the Arab region fell short of providing adequate and comprehensive social protection to a large share of its population. These systems were characterized by fragmentation, consisting of social insurance for those in formal employment (with limited coverage) combined with narrow targeting of non-contributory scheme programs. This created gaps in social protection coverage, comprehensiveness, and adequacy, including access to healthcare, sickness, and unemployment benefits associated with significant underinvestment in social protection. As a result, the human right to social security in the Arab region remains unfulfilled for most of the population.

ii. A large percentage of children still have low or no effective coverage regarding social protection worldwide. Globally around 26.4% of children are covered by social protection benefits. Coverage of children in the Arab region ranges from 32.7% in Lebanon to 0.2% in Oman. However, the Arab region lags behind in children's coverage which accounts for 9.2% compared with other regions. This requires policymakers to implement an integrated social protection system, including child benefits and childcare services, parental leave provision, and healthcare access.

iii. Globally, effective coverage of unemployment protection reaches 18.6% of unemployed workers. In the Arab countries, fewer than 10% of the region's unemployed have access to unemployment benefits, and this has become a matter of concern in the region, especially after COVID-19 highlighted the crucial role of unemployment protection schemes in protecting jobs and incomes.

iv. Some countries worldwide have achieved notable progress in providing universal or near-universal effective maternity coverage. Despite the positive developmental impacts of supporting childbearing women, some countries in the Arab region provide maternity benefits with limited coverage due to high informality levels and low female labor market participation.

v. Access to social protection benefits among people with disabilities globally reaches an average of 33.5%, as compared with low coverage in the Arab region, reaching 15%. After COVID-19, several countries in the world introduced universal disability benefit programs. Still, in the Arab region, persons with disabilities are often excluded from contributory social protection. This exclusion illustrates the urgent need to introduce disability benefits as part of social protection schemes for those with disabilities, which should equally be necessary to fulfill other commitments, such as ending poverty.

vi. Globally, 77.5% of people above retirement age receive old age pension benefits. However, there are still major variations worldwide across different regions, including the Arab region, between rural and urban areas, and between women and men. Only around 40% of older people receive pensions in the Arab region. Some countries in the region provide generous retirement conditions for public sector workers and benefits levels for pension schemes. On the contrary, some countries do not offer adequate minimum benefit guarantees with the absence of automatic pension indexed inflation. The COVID-19 pandemic has placed additional financial pressures on pension systems, but countries have reported that the impact over the long term will be moderate to low. The Arab region faces several challenges to reforming the pension systems, including low levels of economic development, high levels of informality, low contributory capacity, poverty, and insufficient fiscal space.

TOWARD UNIVERSAL SOCIAL HEALTH PROTECTION SYSTEMS IN THE ARAB COUNTRIES

The challenges and opportunities for extending social health protection coverage in the Arab countries are:

i. **Highlighting the need to reduce out-of-pocket payments and the limitations of benefit adequacy, especially after COVID-19.** Social health protection in the Arab region is characterized by low service quality and limited coverage. Coverage varies significantly among countries in the region. Limited health access may have a significant effect on households' health, which causes serious health problems. Additionally, OOP payments are still high in the Arab region. This means that households are responsible for most healthcare costs, reflecting inequality in accessing services

between urban and rural areas. Moreover, other barriers to accessing healthcare remain in the form of physical distance, quality and acceptability of health services, and long waiting times.

ii. **Supporting universal social health protection for all in the Arab region is through key conditions:** rights-based entitlements, broad risk pooling, and collective financing using more and better data to monitor progress on equity and coverage. The COVID-19 pandemic revealed the need to invest in the quality of healthcare services, which requires recruiting, deploying, training, and motivating health workers to ensure the delivery of quality healthcare services. There is a strong linkage and coordination between income security and accession to medical care in addressing key determinants of health more effectively. The pandemic highlighted the crucial role of social health protection in shaping behaviors to foster prevention and the complementarity of sickness and healthcare benefit schemes. Additionally, the urgent need for emerging and special needs requires collective approaches for better healthcare service, including population aging, human mobility, and the increasing burden of prolonged and chronic diseases.

iii. **Developing the benefits and advantages of social insurance:** Arab countries should ensure that the entire population (citizens and residents – including migrants and refugees, and especially women, children, poor households, people with disabilities, and agricultural and informal sector workers) are covered by a cost-effective package of services with consumption of services allocated according to people's health needs – not their willingness or ability to pay. This would require an initial focus on providing a package of public healthcare benefits to all residents who are currently not insured, not only the poorest or most vulnerable. It is worth noting the financial pressures faced by the working poor and middle classes in Arab countries, who may be earning wages but remain vulnerable to sudden shocks due to a lack of savings or indebtedness.

iv. **Simplifying procedures for benefiting from social insurance (and making entitlements easier to understand):** Obstacles to effective coverage include administrative or geographical barriers, non-compliance with registration procedures, or lack of awareness (ILO, 2022). The low effective coverage

in Arab countries is affected by a range of factors such as substantial informality, labor and social security inspection mechanisms with low enforcement capacity, low contributory capacity on the part of employers, a lack of understanding of social insurance, a mismatch between benefits and needs, and complex administrative procedures. Hence, Arab countries should address barriers to accessing social protection – such as physical distance, lack of simple and appropriate information, lack of financial inclusion, and cumbersome and complex administrative procedures. Awareness-raising of staff, disability disaggregated data, non-discrimination and accessibility provisions in regulations and standard operating procedures effectively contribute to greater sensitization to better inclusion requirements. Greater public awareness of rights and entitlements and efforts to improve health literacy among local populations are essential to empowering people to demand health services. Such steps should accompany interventions in the political and institutional environment to improve benefit adequacy, scheme accountability, and the associated perceptions of fairness and trust. Migrant workers can play an important role in addressing labor shortages, particularly in economies with aging workforces, thereby contributing to the sustainability of social security systems.

v. **Enhancing the contribution of social insurance fund investments in economic and social development:** Arab countries need to better adapt financing mechanisms and modalities to the disparate situations of workers and enterprises, ensuring a fair sharing of responsibilities between workers and employers, those who benefit from their work and, where necessary, the government. Further investment in social protection is required now to fill financing gaps. In particular, prioritizing investments in nationally defined social protection floors is vital for delivering on the promise of the 2030 Agenda. Fiscal space exists even in the poorest Arab countries, and domestic resource mobilization is key. However, concerted international support is also critical for fast-tracking progress in those countries lacking fiscal and economic capacities, especially in low-income countries affected by conflict like Libya, Yemen, and Sudan, with marked underinvestment in social protection. Without continued support for social protection expenditure and prolongation of emergency measures, many countries face the possibility of the "cliff fall" scenario.

vi. **Extending social protection as a tool addressing crises (armed conflicts, economic and financial crises, COVID-19):** Efforts on shock-responsive social protection require balancing humanitarian and development perspectives. Therefore it is crucial to work with other partners and leverage each others' strengths to support governments in developing social protection systems that can better prepare and respond to shocks in the country. This collaboration and coordination is needed at different levels: (i) Collaboration with different ministries/departments (social development, disaster risk management, finance, planning); (ii) Collaboration with development and humanitarian stakeholders on a common agenda; working alongside other development partners (e.g., WFP, World Bank, UNHCR) to avoid duplication or gaps in provision; (iii) National-level collaboration with teams working on emergency responses and other sectors is also needed. This would broadly entail mapping of stakeholders, their circles of influence, motivations, and capacities; development of a common understanding of concepts and processes on shock-responsive social protection; identification of a common roadmap with clarity on roles and responsibilities based on interest and capacity; and influencing humanitarian programming to better align with planned and ongoing efforts on shock responsiveness.

vii. **Opportunities and challenges associated with digital social protection:** In some cases, social protection responses have magnified the challenges in accessing benefits faced by those who were already difficult to reach, such as those without access to digital technologies. The COVID-19 crisis has highlighted the need to build inclusive delivery systems. Arab countries were hard-pressed to identify those in urgent need of additional protection against the health and economic risks facing them – especially informal economy workers – and to disburse benefits to them rapidly and safely. In many Arab countries, digital technologies were crucial to identifying beneficiaries and delivering benefits to them and were used in creative and innovative ways. Countries that had pre-existing digital social registries, like Jordan, Egypt, and the Arab Gulf states, were able to respond faster and more efficiently during the pandemic. However, digital technologies also carry exclusion risks. Where people do not have access to banks and financial services, lack digital literacy, and/or do not have access to smartphones, they may end up doubly excluded. Furthermore, those countries that actively extended provision to reach hitherto uncovered groups of

the population, including through digital technology, and included them in national registries, established a basis that could enable the further extension of social protection. For example, reliance on digital methods of outreach, registration, and payout may have exclusionary effects for women – as for other vulnerable groups – due to the gendered nature of the digital divide, namely the uneven distribution of ownership of, access to, and knowledge of new technologies. The same exclusions apply to people with disabilities and older people.

viii. **Establishing grievance mechanisms that support accountability:** Social protection policies in the Arab region have not been sufficiently sensitive to the circumstances of marginalized groups like women, migrants and refugees, ethnic minorities, older people, and people with disabilities. In many cases, these groups may not have sufficient information about their rights. Transparency, as well as effective grievance and appeal mechanisms, are needed to ensure that all actors are fully aware of their rights and responsibilities; that legal frameworks provide for clear and predictable entitlements; and that administrative procedures are as simple and transparent as possible, fully harnessing the potential of digital technologies while protecting personal data, respecting privacy, and ensuring that non-digital solutions remain in place for those who may not be able to use digital technology. Citizens and residents should have trust and confidence that their appeals are heard fairly and alternative sources of support are made available where eligibility is not established for a social protection benefit.

FUTURE DIRECTIONS: KEY CONCLUSIONS AND POLICY RECOMMENDATIONS

CONCLUSION AND POLICY OPTIONS FOR UNIVERSAL SOCIAL PROTECTION

i. Fundamentally, governments of the Arab region should address the fundamental structural issues and place social protection at the core of a new social and economic paradigm. This requires an urgent need to improve, sustain and expand spending on social protection to ensure its adequacy and coverage and create fairer and more inclusive societies to unlock opportunities for inclusive growth, tackle poverty and inequality effectively, and avoid the progressive impoverishment of the missing middle.

ii. Social protection floors in the Arab region should guarantee at least basic income security and access to healthcare services for all. To achieve systematic change, rights-based social protection benefits that address life cycle risks have a critical role in filling coverage gaps. Non-contributory schemes should be used to minimize exclusion errors; however, these schemes cannot be seen as a substitute for developing a contributory social protection system. Universal social protection can be achieved by combining social insurance and tax-financed programs through well-designed systems and building more integrated institutional governance and administration models.

iii. The COVID-19 pandemic has highlighted coverage gaps for temporary, casual, part-time, and self-employment workers, including seasonal workers, agricultural and domestic workers, and those in the informal sector. Governments in the Arab region should provide all workers and their families with access to at least basic income protection to establish a more diversified and sustainable financing base for social protection.

iv. Migrant workers and refugees, who are subject to discrimination and unequal treatment, must be given special attention to access the social protection system, including healthcare. Efforts should be undertaken to align social protection programs with the humanitarian–development nexus and enhance the shock responsiveness of systems across the region.

v. Progressive reforms of contributory schemes, including pension systems in the Arab region, should aim at improving fairness across labor market segments and across and within generations. Despite their financial burden, these reforms need to ensure a fair balance between sustainability, coverage, and adequacy.

vi. Investment in social protection needs structural transformations in the employment and economic paradigms prevailing in the Arab region. Contributory and non-contributory schemes should gear towards promoting formalization and facilitating the labor market participation of young people and women. Furthermore, it is important to strengthen social protection benefits during working life and medical care schemes.

vii. Expansion in social protection spending requires increasing spending efficiency and designing options to mobilize fiscal resources through enhancing the progressivity of the tax system, reallocating public expenditure to investment in social sectors, and tackling tax evasion and avoidance.

viii. International support and innovative financing mechanisms for social protection are necessary to avoid fragility, debt sustainability, or capacity constraints.

ix. Participation and social dialogue of all relevant stakeholders are essential to ensure that a new social protection paradigm is sustainable, fair, and acceptable, particularly for vulnerable workers and groups.

x. Management information systems and monitoring and evaluation are crucial in building comprehensive social protection systems. This requires establishing central repositories of information and effective data collection to enhance coordination and complementarity in service delivery.

CONCLUSION AND POLICY OPTIONS FOR UNIVERSAL SOCIAL HEALTH PROTECTION

i. Strategies for implementing universal healthcare will depend on specific country contexts, existing health system arrangements, the country's fiscal capacity and public values. They will have to combine a mix of health financing mechanisms to accelerate the achievement of universal coverage and to balance equity, efficiency, and quality of care (ILO 2008). Arab countries have made some progress

in increasing population coverage; however, significant barriers to accessing healthcare remain in the form of OOP payments on health services, physical distance, limitations in the range, quality, and acceptability of health services, and long waiting times, as well as opportunity costs such as lost working time. The COVID-19 crisis has highlighted the limitations of benefit adequacy and the need to reduce out-of-pocket payments. Hence, a major principle that Arab countries should adopt is that universal access needs collective financing, broad risk-pooling, and rights-based entitlements as key conditions for supporting effective access to healthcare for all in a shock-responsive manner.

ii. More and better data on legal coverage needs to be collected as a matter of priority to monitor progress on coverage and equity. A second element is that investment in the availability of quality healthcare services is crucial. The COVID-19 pandemic has further revealed the need to invest in healthcare services, improve coordination within health systems, and provide adequate healthcare staff training and recruitment. Transparent and sustainable reforms of social protection systems in Arab countries can lead in the long run to a gradual expansion of social insurance and health coverage, as highlighted in the Social Protection Floor Framework. The starting point for such reforms is comprehensive legal coverage through the right to health in national constitutions.

iii. A major challenge for Arab health ministries is enforcing policies and laws. Indeed, corruption and tense political situations have enabled many to disregard laws or policies. Prevention should be part of the health reform in the Arab world, and ways in which it can be incorporated into social health protection schemes must be further developed. Unfortunately, many Arab countries invest in treatment rather than prevention and long-term planning. Most Arab countries have weak health information systems. The vital statistics in most Arab countries are non-existent, which produces challenges for sound policy and prevention programs. Indeed, some health information responsibilities are not managed by ministries of health. For example, the Ministry of Interior is in charge of death registries in some countries in the region. A call to establish (in most) and improve (in some) health information systems is necessary.

iv. Where civil society is concerned, some key recommendations as noted by WHO and the Arab League (2015) are: Arab states should build trust and promote a more enabling

legislative environment for civil society organizations, workshops, and training courses for civil society organizations in Arab states to raise awareness of the SDGs and promote civil society participation in them. Further support is needed in the development of criteria for the assessment of civil society organizations, particularly for those that are health-related. Supporting capacity-building of civil society organizations through organizing training-of-trainers courses to ensure sustainability and building capacities in health priorities, proposal writing, project planning and implementation, and promotional campaigns is also necessary. A further option may be the establishment of liaison offices at ministries of health to act as an interface with civil society organizations.

REFERENCES

- Alami, R. 2022. "Towards a "new normal" in health policies in the Arab countries." Economic Research Forum, Working Paper, (1537). Link.
- Alami, R. 2017. "Health financing systems, health equity and universal health coverage in Arab countries." Development Change, 48(1): 146-179. Link.
- Batniji, R. et al. 2014. "Governance and health in the Arab world." The Lancet, 383(9914): 343-355. Link.
- Bird, N., & Silva, W. 2020. "The role of social protection in young people's transition to work in the Middle East and North Africa." IPC-IG Research Report, 41. Link.
- Food and Agriculture Organization of the United Nations (FAO). 2013. "FAO Statistical Year Book 2013 World Food and Agriculture." Food and Agriculture Organization, United Nations. Link.
- International Labour Organization (ILO). 2021a. "World Social Protection Report 2020-2022: Social protection at the crossroads – in pursuit of a better future." International Labour Organization (ILO). Link.
- International Labour Organization (ILO). 2021b. "World Social Protection Report 2020–22: Regional companion report for the Middle East and North Africa (MENA) region." International Labour Organization (ILO). Link.
- International Labour Organization (ILO). 2020. "World employment and social outlook." International Labour Organization (ILO). Link.
- International Labour Organization (ILO). 2017. "Fiscal space for social protection and the SDGs: Options to expand social investments in 187 Countries." International Labour Organization (ILO), ESS Working Paper 48. Link.
- International Labour Organization (ILO). 2008. "Social Health Protection: An ILO strategy towards universal access to health care." International Labour Organization (ILO). Link.
- International Monetary Fund (IMF). 2022. "Revenue mobilization for a resilient and inclusive recovery in the Middle East and Central Asia." Departmental Paper, DP/2022/013. Link.
- Machado, A. C., et al. 2018. "Overview of non-contributory social protection programmes in the Middle East and North Africa (MENA)

region through a child and equity lens." International Policy Centre for Inclusive Growth United Nations Development Programme and the United Nations Children's Fund, p. 348. Link.

- Megersa, K. 2019. "Lessons learned from linking social protection to taxation." Institute of Development Studies, Helpdesk report. Link.
- Onarheim, K. H., & Rached, D. H. 2020. "Searching for accountability: Can the WHO global action plan for refugees and migrants deliver?" BMJ Global Health, 5(6): 3–7. doi: 10.1136/bmjgh-2019-002095. Link.
- Talaat, W. 2022. "Social protection as a budget priority." In Mohieldin, M. "Financing Sustainable Development in Egypt', League of Arab States. Link.
- United Nations (UN). 2020. "Policy brief: The impact of COVID-19 on the Arab Region: An opportunity to build back better." United Nations, p. 27. Link.
- United Nations Economic and Social Commission for Western Asia (UN-ESCWA). 2021. "The COVID-19 pandemic in the Arab region: An opportunity to reform social protection systems." United Nations Economic and Social Commission for Western Asia (ESCWA). Link.
- United Nations Economic and Social Commission for Western Asia (UN-ESCWA). 2019. "Social protection reform in Arab countries." United Nations Economic and Social Commission for Western Asia (ESCWA). Link.
- United Nations Economic and Social Commission for Western Asia (UN-ESCWA). 2017. "Strengthening social protection for persons with disabilities in Arab countries." United Nations Economic and Social Commission for Western Asia (ESCWA), p. 91. Link.
- United Nations Economic and Social Commission for Western Asia (UN-ESCWA). 2020. "Impact of COVID-19 on migrants and refugees in the Arab Region." United Nations Economic and Social Commission for Western Asia (ESCWA), p. 1–25. Link.
- United Nations Development Program (UNDP). 2016. "Leaving no one behind: A social protection primer for practitioners." Link.
- Universal Social Protection 2020 (USP2030). 2015. "Together to achieve universal social protection by 2030 (USP2030)." Global Partnership for Universal Social Protection, Geneva. Link.
- World Health Organization (WHO). 2019. "Report: Regional meeting to develop a regional action plan to promote the health of migrants, refugees and displaced populations." Cairo: WHO Regional Office for the Eastern Mediterranean, license: CC BY-NC-SA 3.0 IGO.

annd
Arab NGO Network for Development
شبكة المنظمات العربية غير الحكومية للتنمية

The Arab NGO Network for Development

works in 12 Arab countries, with 9 national networks (with an extended membership of 250 CSOs from different backgrounds) and 25 NGO members.

P.O.Box Mazraa 5792/14 Beirut, Lebanon

AMERICAN UNIVERSITY OF BEIRUT
FACULTY OF HEALTH SCIENCES

The Faculty of Health Sciences at the American University of Beirut

aims since its inception to shape the public health discourse by preparing professionals to be agents of change, and producing research that impacts practice and policy, and thus the health of populations.

American University of Beirut
P.O.Box 11-0236 / Faculty of Health Sciences
Riad El-Solh / Beirut 1107 2020
Lebanon